

# VHA Performance Measurement In Cardiac Care

*A Map for VHA Cardiac  
Performance Measurement in  
FY 2005 and beyond...*

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# Needs Assessment Prioritization Phase

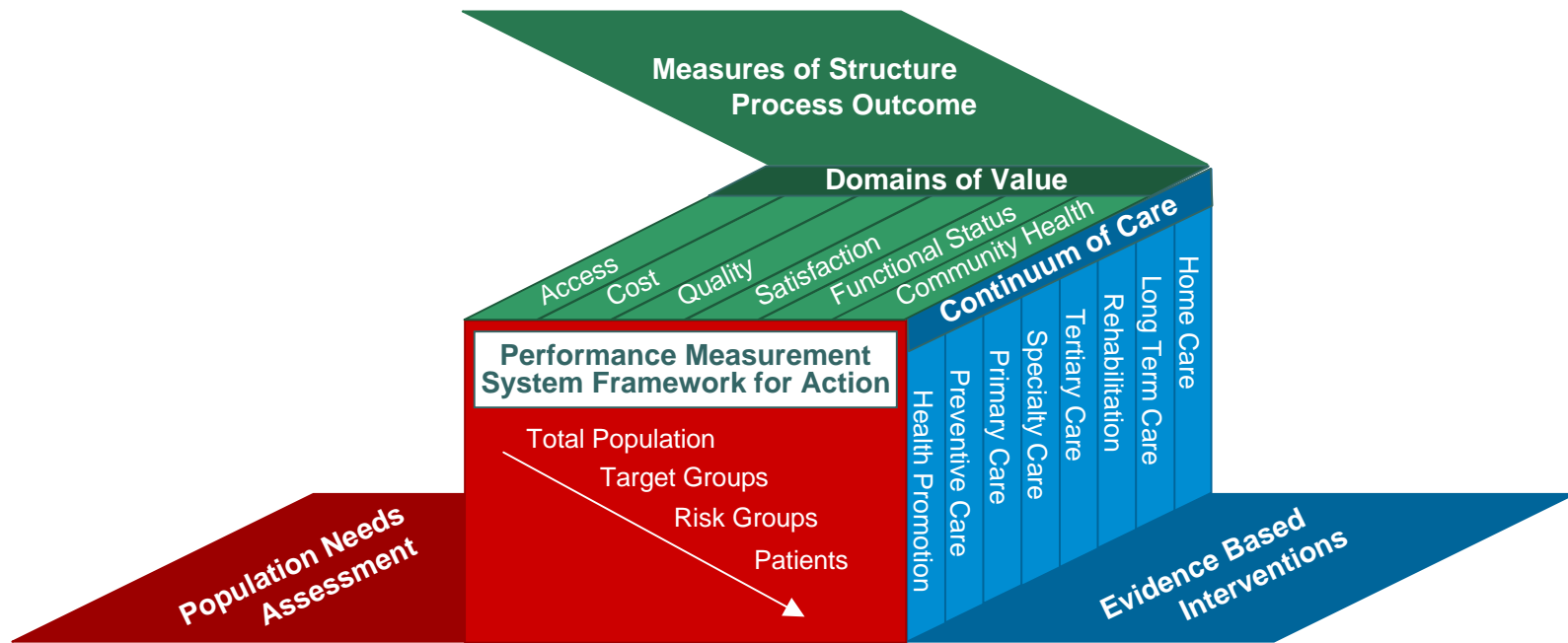
Performance Measurement  
System Framework for Action

Population Needs  
Assessment

Total Population  
Target Groups  
Risk Groups  
Patients

- Inventory the health of and risk inherent in the population served
- Gain insight into disease and trajectory of illness for critical populations
- Estimate the burden of illness (patient and health care system)
- Gap Analysis of requirements
  - New or improved service is needed
  - Outcomes less than optimal
  - Update to existing practice, process or service
  - New skills, capacity, capabilities or infrastructure
- Target an 'at-risk population'

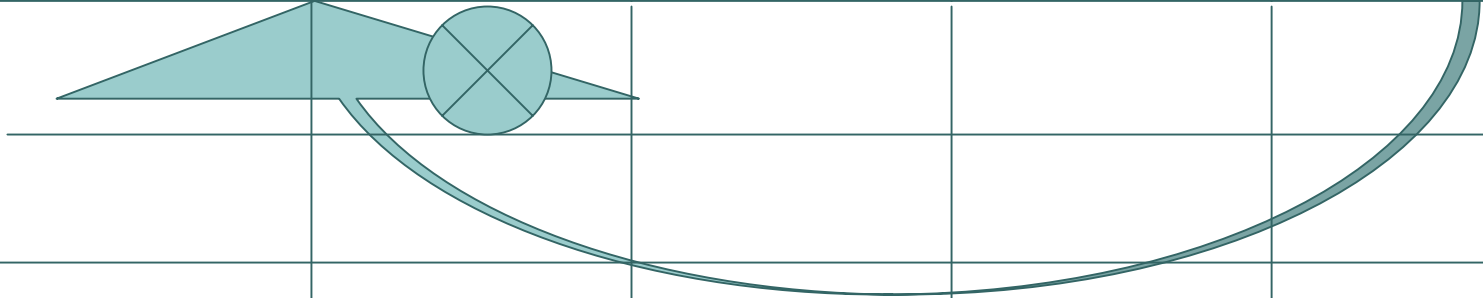
# Performance Measurement System Framework for Action



# Continuum of Cardiovascular Disease HTN

Days

7 30 60 360

Clinical Strategy	Primary Prevention	Secondary Prevention	Initial Presentation	Discharge	Follow-up
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					



# Recommendations to Improve BP Control and Management

## Providers

- Greater use of thiazide-type diuretics
- Greater use of fixed-dose combinations
- Need for at least 2-3 AHT drugs in majority of HT patients
- Rational combining of AHT medications, as per various guidelines

## Systems

- Proper BP Measurement
- Recording of BP in CPRS VS package
- Use of hypertension clinical reminders
- Feedback to providers, VAMCs, and VISNs on BP control and AHT medication usage
- Use of home BP manometers to improve adherence

## Patients

- To know their BP numbers
- To know their BP goals
- In lifestyle recommendations to prevent or treat hypertension
- That most patients need at least 2-3 drugs to control BP
- On proper BP measurement



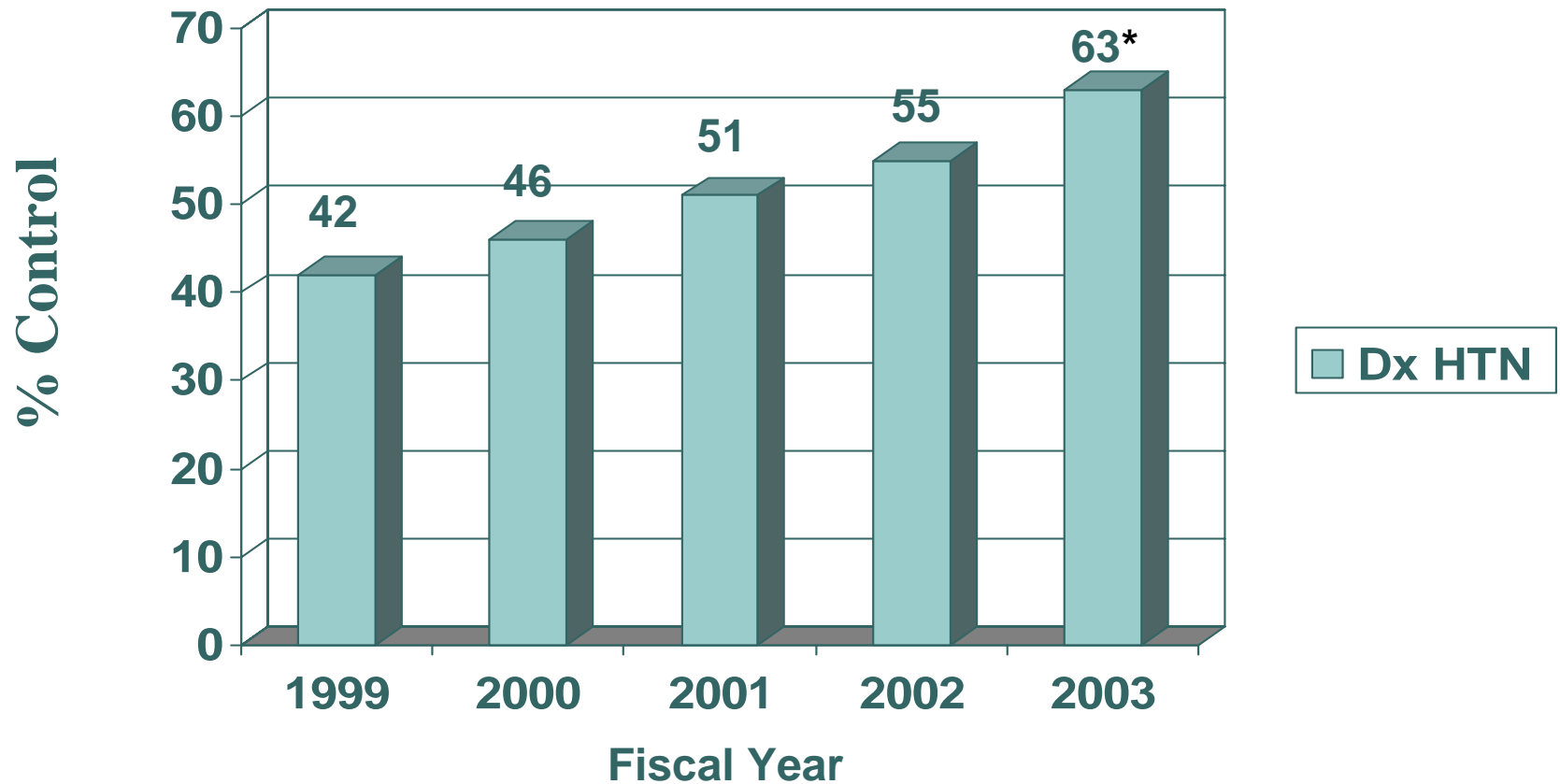
# BP Control and Management in VHA

- Optimize secondary prevention strategies in the management of HTN
- Series by Name –

For patients with an active diagnosis of HTN:

- Percent of patients with BP  $\leq$  140/90 (PM)
- Percent of patients with BP  $\geq$  160/100 or not recorded (PM)

# Patients with Diagnosis of HTN BP Control rates < 140/90

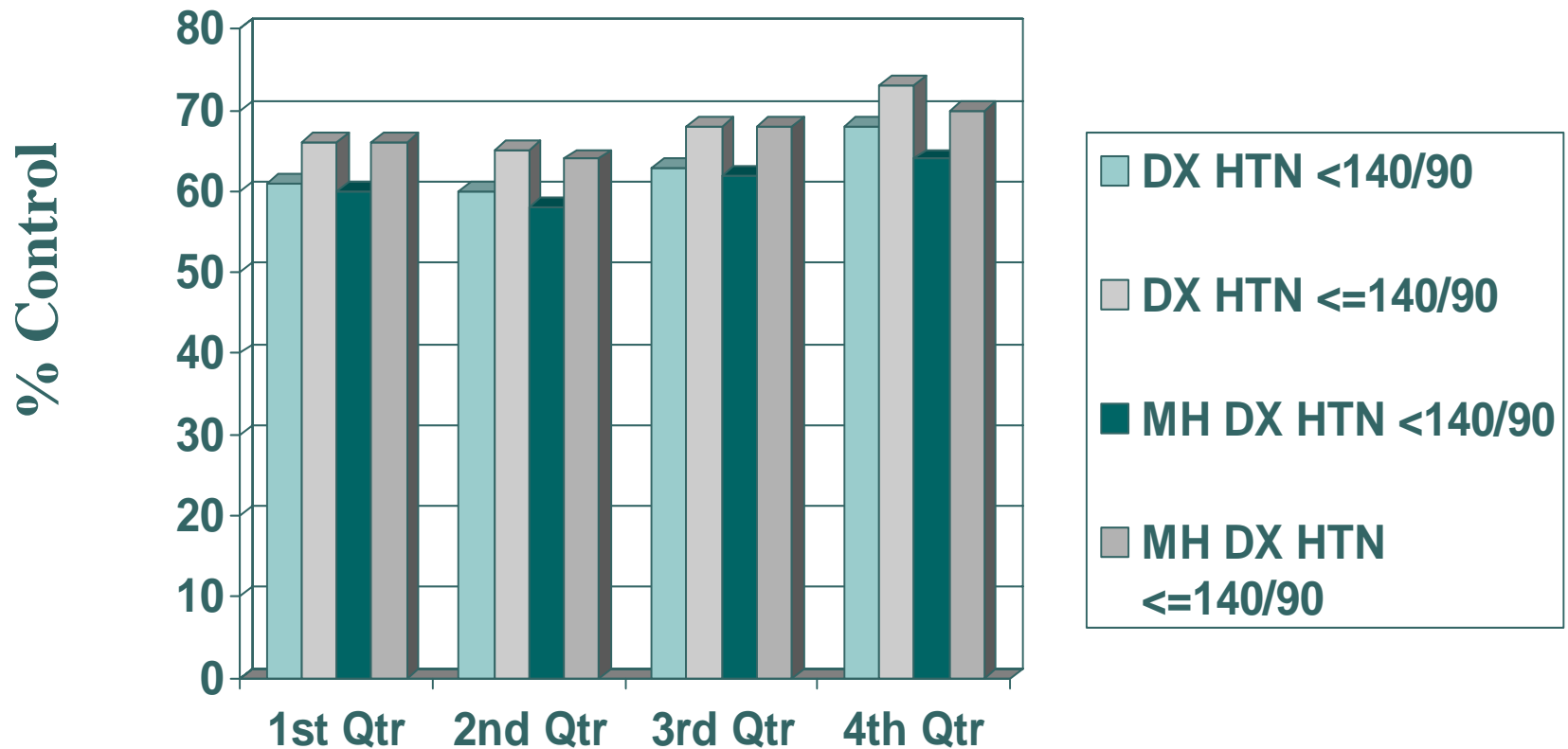


•Note\*5% higher in 2003 when  $\leq 140/90$  mm Hg used as criterion (to be comparable to HEDIS)

# FY 2003 All Cases Sampled

## Percent BP < 140/90 VS

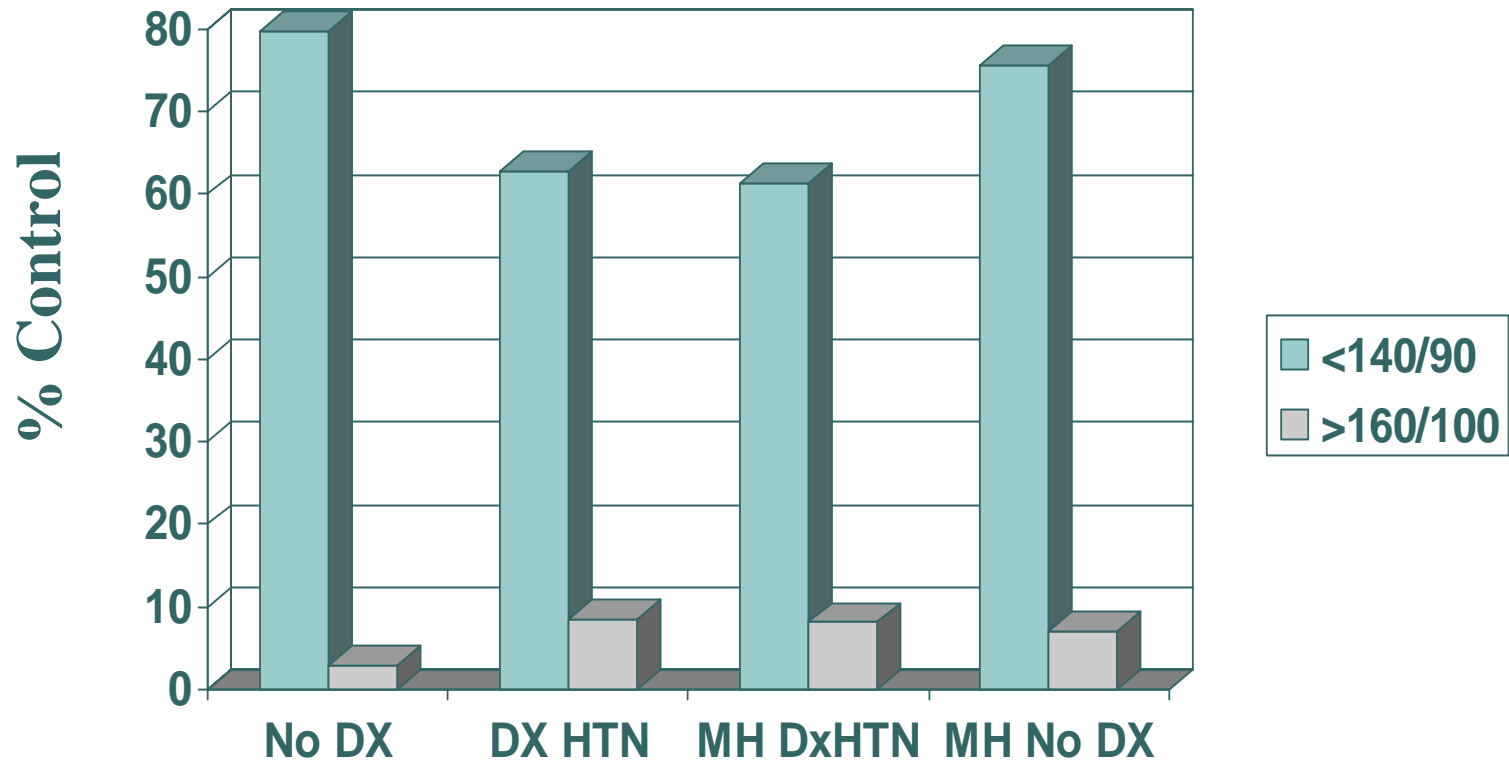
## Percent BP ≤ 140/90



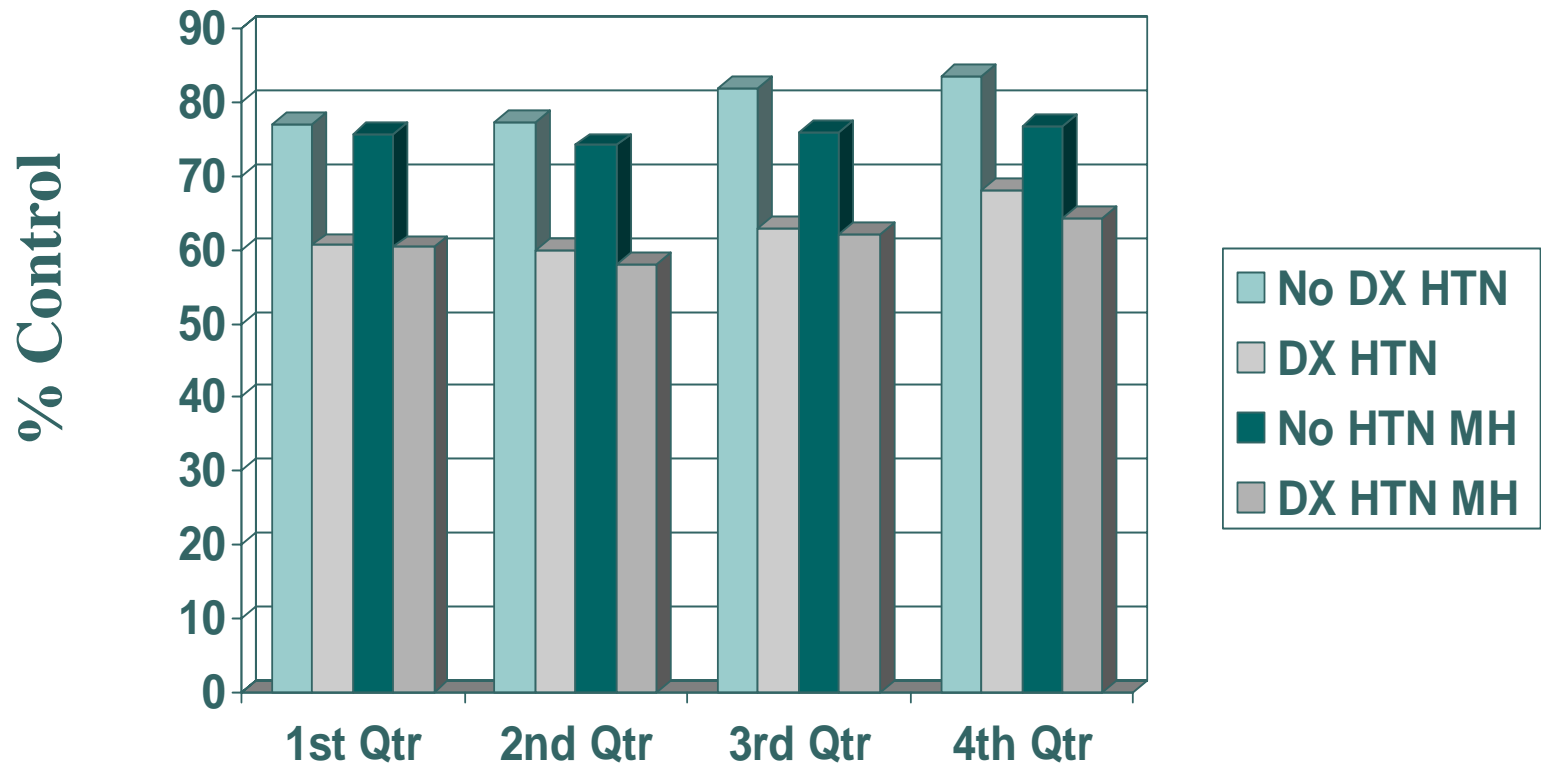


# All Cases Sampled in 2003

## Blood Pressure Control in Four Cohorts

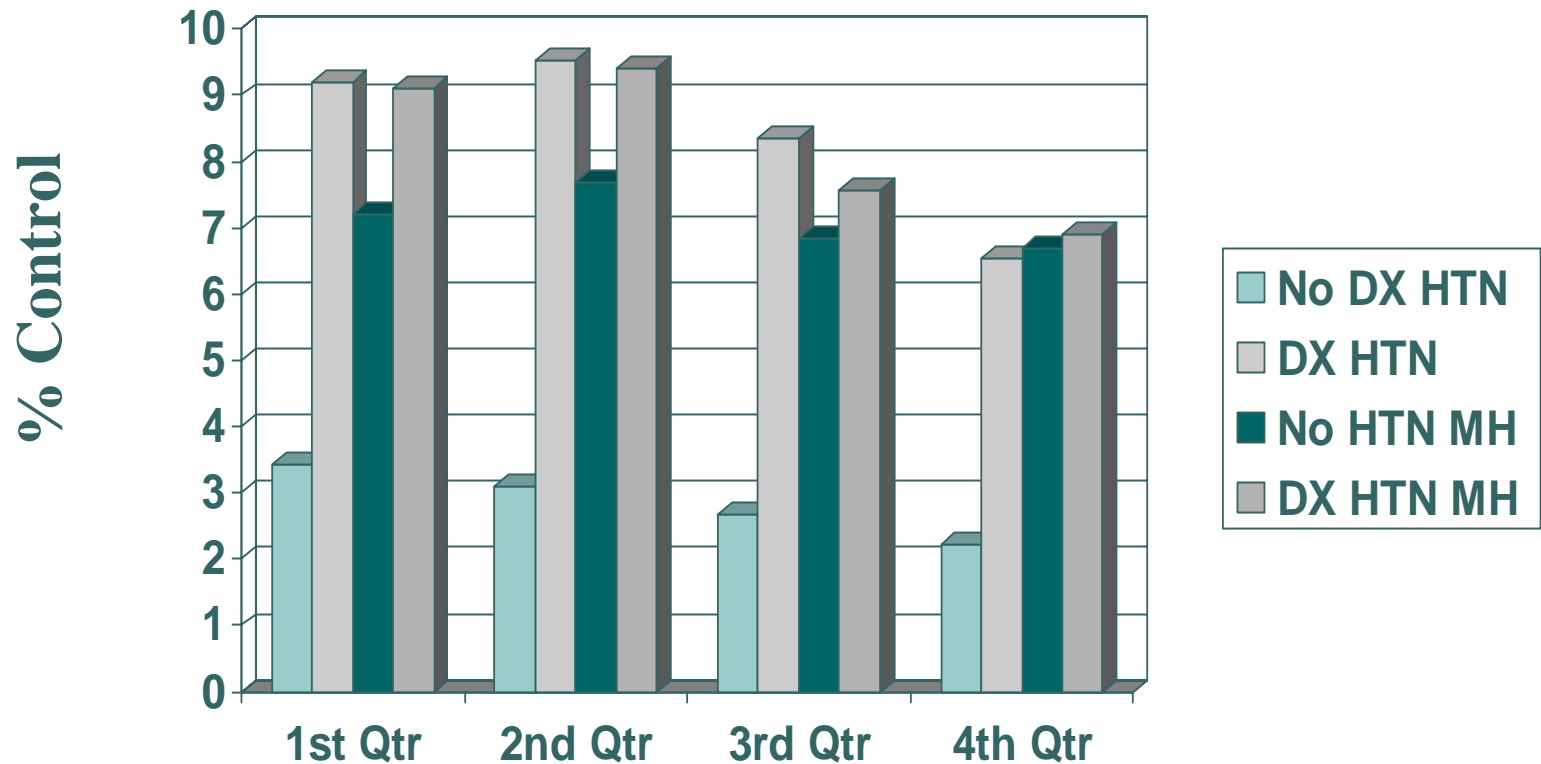


# FY 2003 All Cases Sampled by Quarter Percent BP < 140/90



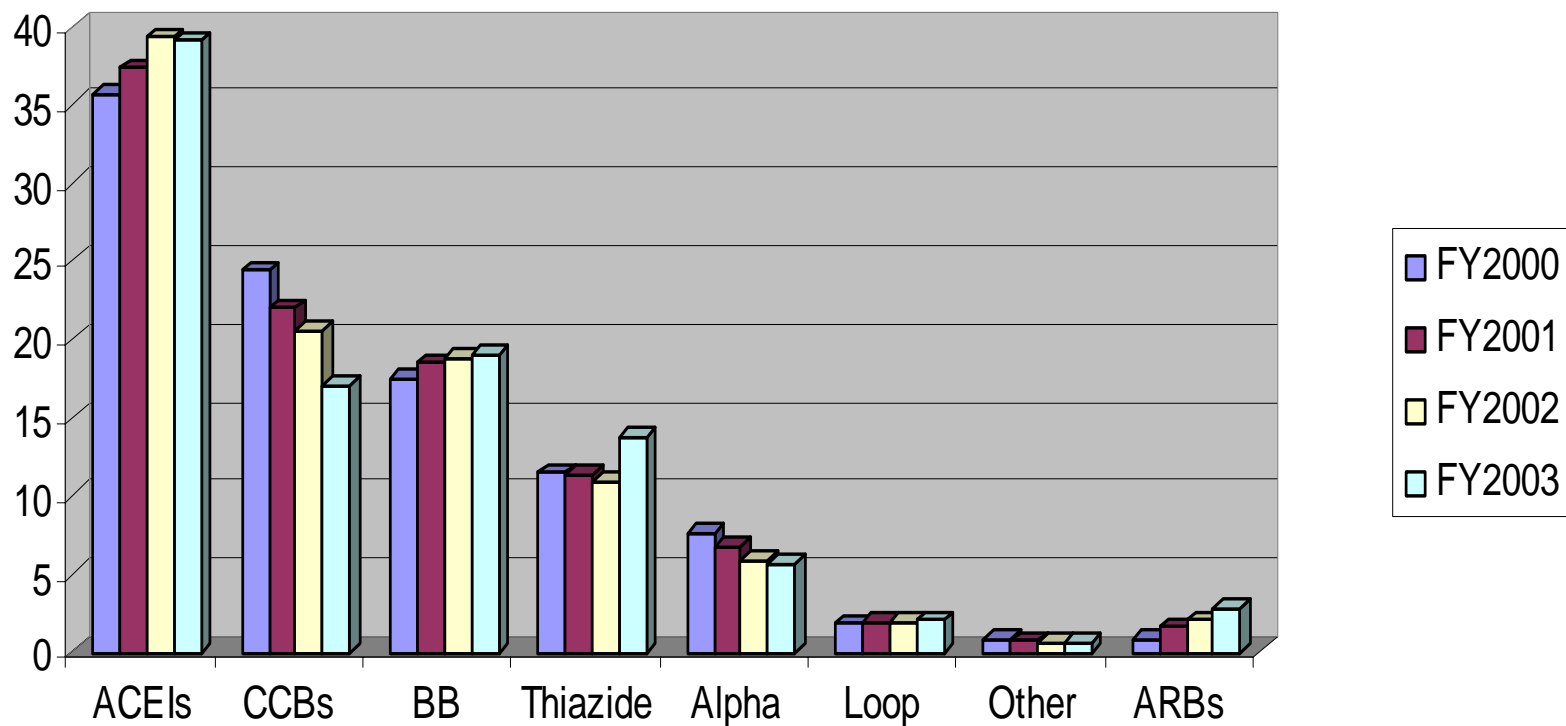
# FY 2003 All Cases Sampled

## Percent BP > 160/100



# Antihypertensive Medications

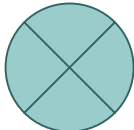
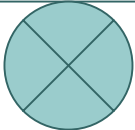
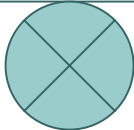
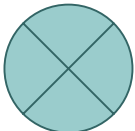
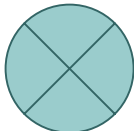
## Patients on Monotherapy



# Continuum of Cardiovascular Disease - HF

*Days*

7 30 60 360

	<i>Primary Prevention</i>	<i>Secondary Prevention</i>	<i>Initial Presentation</i>	<i>Discharge</i>	<i>Follow-up</i>
<i>Assessment Risk</i>					
<i>Evaluation Testing</i>					
<i>Therapy</i>					
<i>Education Counseling</i>					
<i>Clinical Events</i>					

# Secondary Prevention in Heart Failure – Antecedent Care

- Optimize the Outpatient Management of Heart Failure in an effort to prevent HF admissions
- Series by Name –

For Hospitalized HF patients:

- Percent of HF Inpatients with EF<40 on ACEI prior to admission (PM)
- Percent of HF Inpatients with weight instruction prior to admission (PM)
- Percent of HF Inpatients with discharge instructions in weight, diet, and medications (PM)

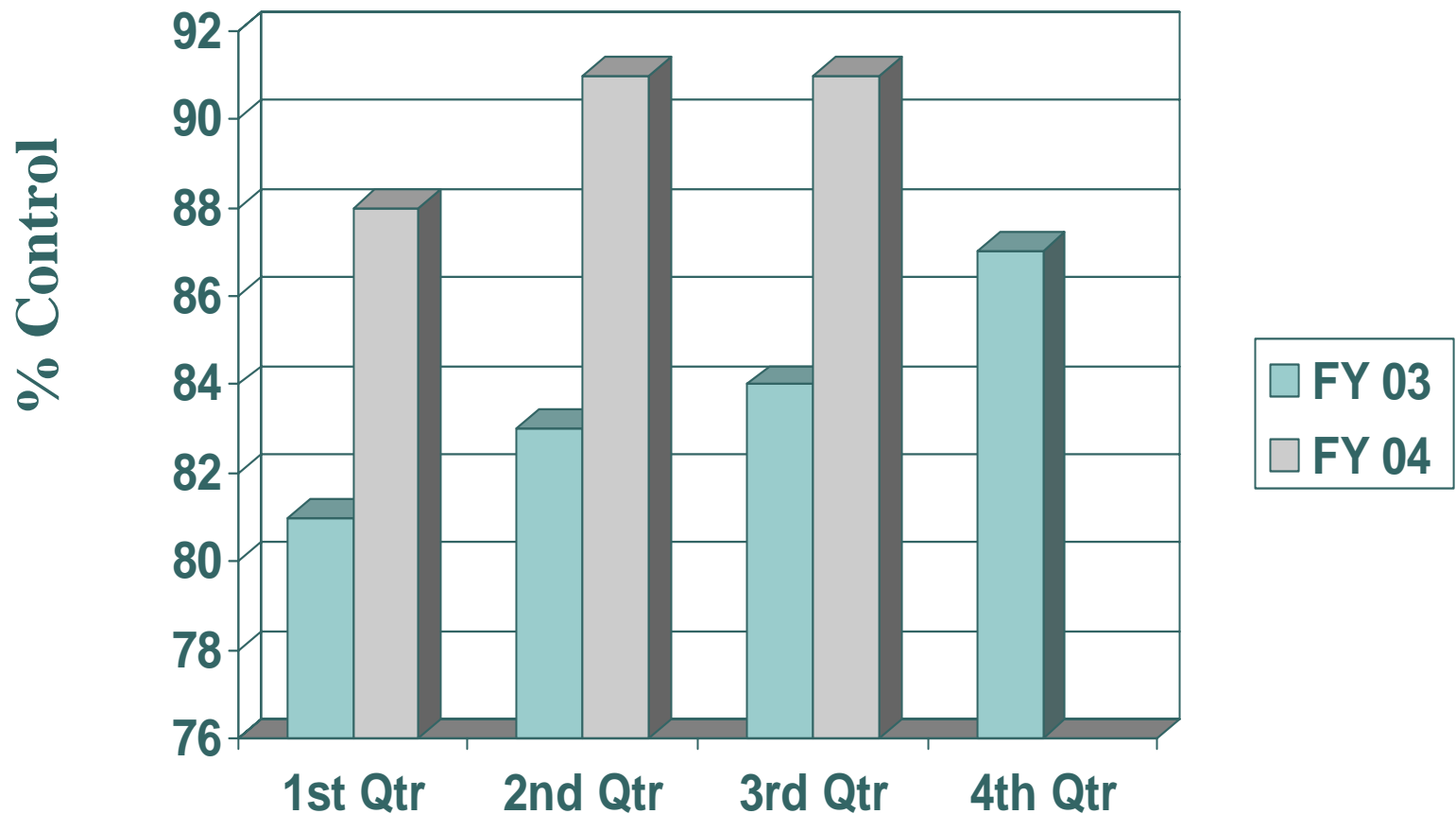


# Indicator Highlights – Secondary Prevention

- Why –
  - HF as an ambulatory care sensitive condition
  - 80/20 rule HF in top 5 VHA diagnosis with high readmission rates
  - Low likelihood of treatment by multiple providers
  - Preventive strategies often under-prescribed
  - Patient education key in managing this chronic condition

# Antecedent Care – HF

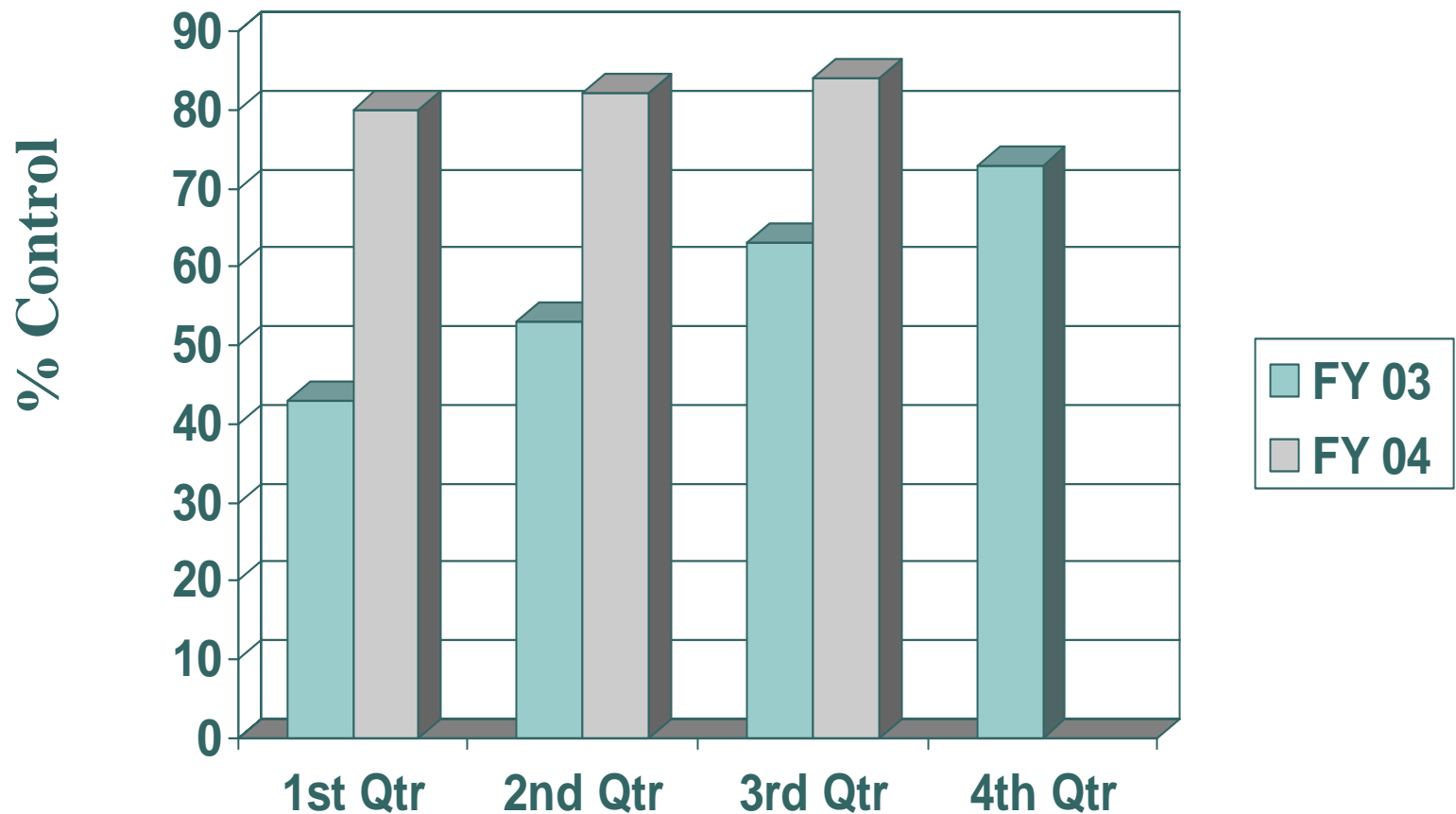
## Inpatients with EF<40 on ACEI Prior to Admission



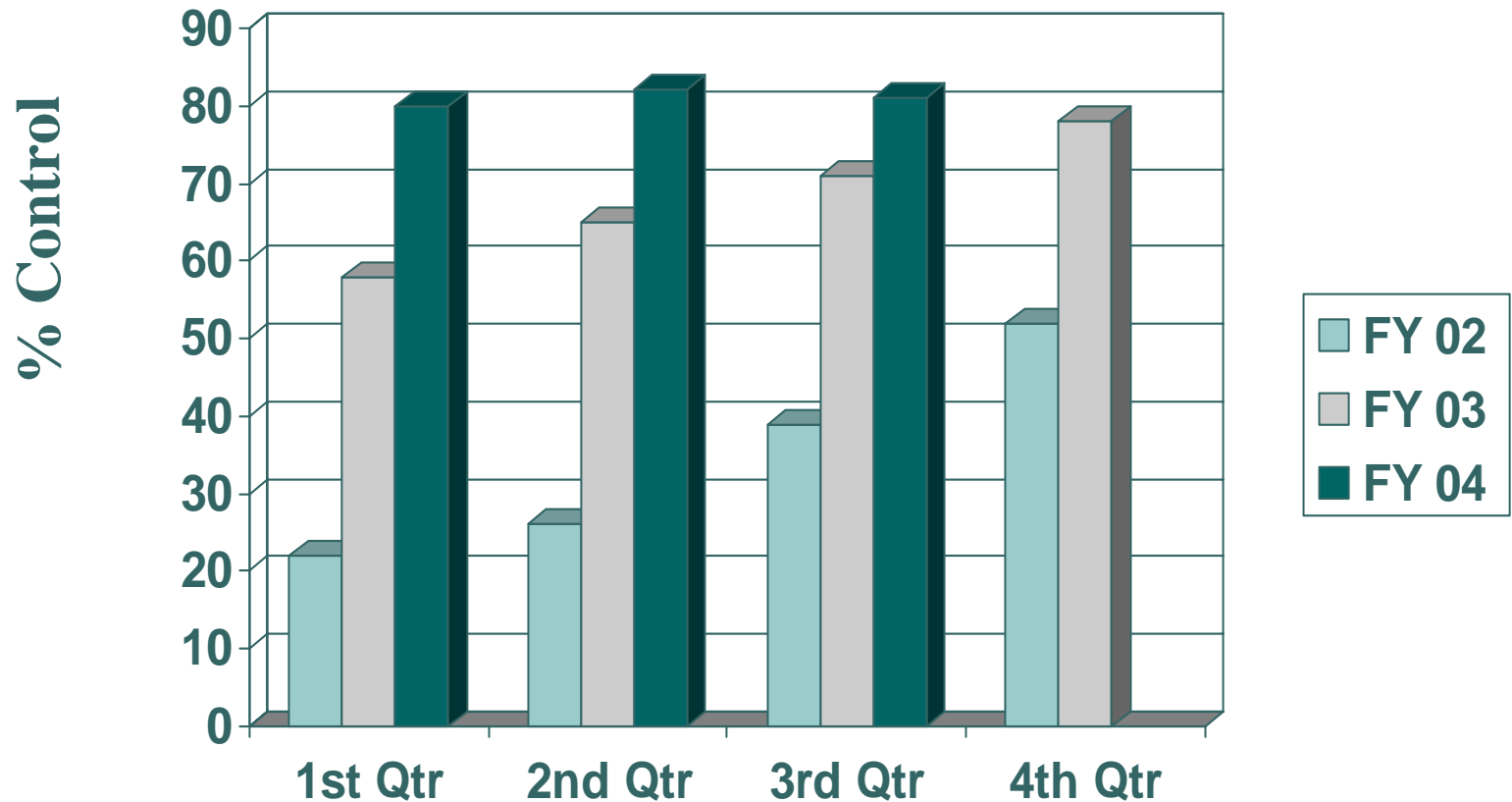


# Antecedent Care – HF

## Inpatients with Weight Instruction Prior to Admission



# HF Inpatients with Diet, Weight, and Medication Instruction Prior to Discharge

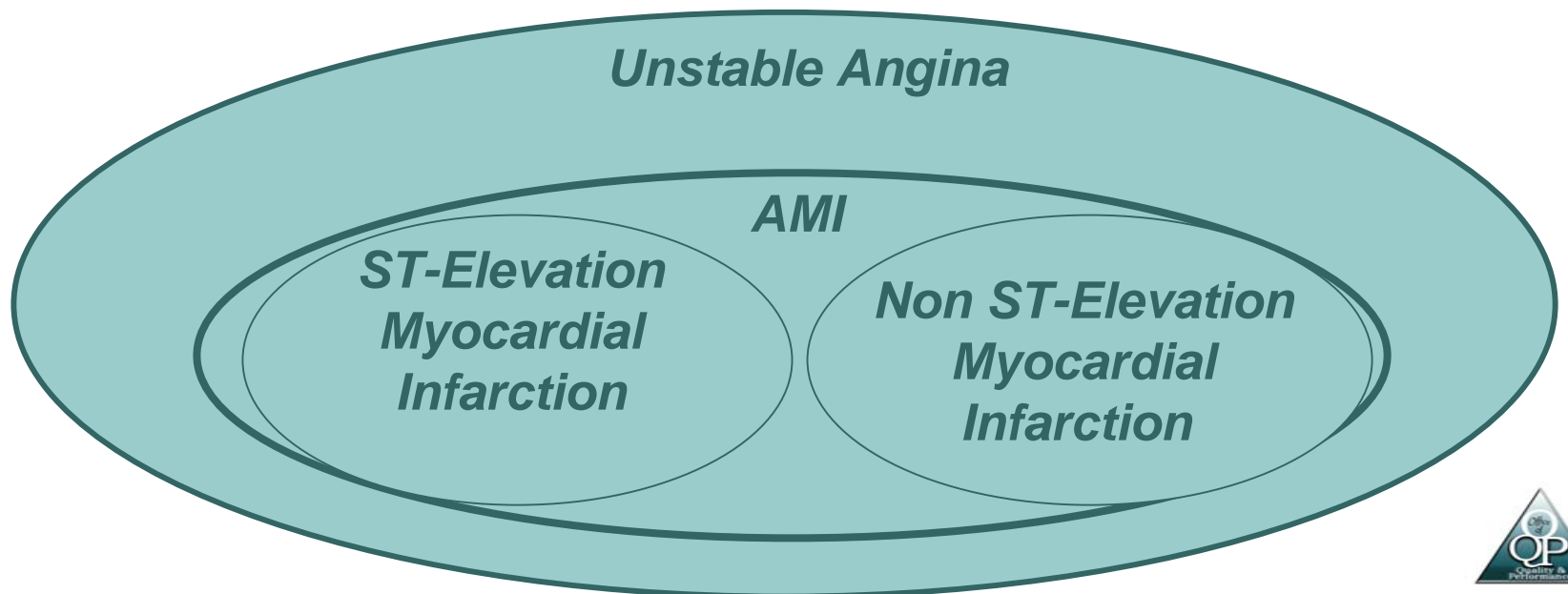


# Acute Coronary Syndrome

- Manifestations Continuum of ACS

*Asymptomatic* ← → *Angina & CHF*

## Acute Coronary Syndrome






# Coronary Artery Disease

- 5-7 million seen annually with ACI
  - 50% false positive rate among ACI admissions
  - 5% ACI and 3% AMI false negative rate
  - STEMI 30%, NSTEMI 25%, UA 38%, 7% Misc.
- In VHA
  - STEMI 24%, NSTEMI 38%, UA 33%, 4% Misc.
  - Over 25,000 admission to VHA facilities



# Challenges Time to Treat

- AMI, UA, from non-cardiac causes
- Survival and degree of damage depends on rapid diagnosis and appropriate treatment
- Interrupt cascade (plaque, thrombus, flow, ischemia, necrosis)
- *Given the relationship between treatment delay and death, *
- *a determination of the likelihood of acute ischemia caused by coronary artery disease should be made in all patients with chest pain*

# Acute Coronary Syndrome in VHA

First facility ...	Tertiary	Non-tertiary	Non-VA Hospital	Total
STEMI seen in <12	151 (52%)	80 (28%)	56 (20%)	287 (11%)
STEMI seen in >12	132 (56%)	68 (29%)	34 (14%)	234 (9%)
NSTEMI	425 (54%)	207 (27%)	147 (19%)	779 (31%)
UA	401 (60%)	215 (32%)	47 (7%)	663 (26%)
Unable to stratify risk	277 (48%)	188 (32%)	115 (20%)	580 (23)%
Total	1386 (54%)	758 (30%)	399 (16%)	2543 (100%)

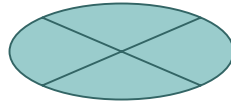
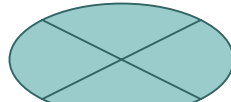
# Comparing Codes to Classification

<b>ICD9 Code</b>	<b>410</b>	<b>411</b>	<b>Total</b>
<b>STE MI</b>	86%	14%	24%
<b>NSTE MI</b>	80%	20%	38%
<b>Unstable Angina</b>	6%	94%	33%
<b>Missing</b>	9%	91%	4%
<b>Total</b>	1365 <b>54%</b>	1178 <b>46%</b>	2543 <b>100%</b>

# Continuum of Cardiovascular Disease - Acute Coronary Syndrome

Days

7 30 60 360

	<i>Primary Prevention</i>	<i>Secondary Prevention</i>	<i>Initial Presentation</i>	<i>Discharge</i>	<i>Follow-up</i>
<i>Assessment Risk</i>					
<i>Evaluation Testing</i>					
<i>Therapy</i>					
<i>Education Counseling</i>					
<i>Clinical Events</i>					



# Early|Continual Risk Stratification

	<i>Initial Presentation</i>	<i>Cardiac Care / 1st 24 Hours</i>	<i>Hospital Phase</i>	<i>Pre- Discharge</i>	<i>Follow-up</i>
<i>GOAL:</i>	<b>Identify early invasive v.s. medical candidates</b>	<b>Assess effective- ness of acute intervention and need for rescue</b>	<b>Segregate complicated from uncomp- licated infarction and UA</b>	<b>Assess stabilized patient risk and identify candidate for cath and plan for further testing</b>	<b>Execute plan for further testing, rehabilita- tion, and risk factor modifica- tion</b>
<i>Physical Exam</i>					
<i>History</i>					
<i>ECG</i>					
<i>Biochemical Markers</i>					
<i>Invasive Procedures</i>					
<i>Noninvasive Testing and Imaging</i>					

# Assessment and Risk Stratification at Initial Presentation

- Optimize the Diagnosis and Management of ACS through stratification into appropriate treatment groups
- Series by Name –

For Hospitalized ACS patients:

- Initial Risk Stratification *variable collection*
- Timely (10 Minutes) In-hospital EKG (PM)
- Timely (60 Minutes) initial result of serial troponin measurement (PM)
- High risk and moderate-high risk - Cardiology involvement within 24 hours (PM)



# Indicator Highlights – Risk

- Why –
  - Highest risk benefit most from aggressive interventions
  - Low risk care can be more selective and resource efficient
- Targeted evidence based intervention, risk reduction, and enhanced survival
- Early and continual quantification of short-term and long term risk
- Discriminatory capability of models balance between simplicity and complexity
- Drive recording of and collection of these variables

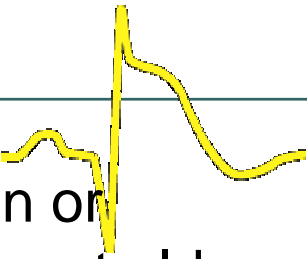
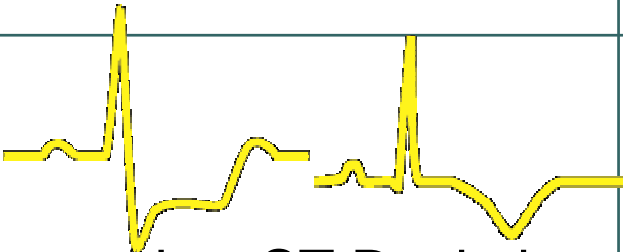


# Risk Stratification

- Tools: TIMI-STEMI, GUSTO STEMI, TIMI-NSTEMI, PURSUIT-NSTEMI, PREDICT, CCP (Crusade)
- Demographics
  - Age, female, ethnicity
- Physical examination and hemodynamics
  - BP, Pulse, CHF, Shock, pulmonary edema
- Medical history and risk factors
  - DM, HTN, angina, prior MI, coronary stenosis, or stroke, preadmission medications, anginal history
- ECG
  - Infarction location, ST<sup>↑</sup>, number of leads
- Biochemical markers
  - Elevated troponin, CK-MB

# Indicator Highlights – ECG

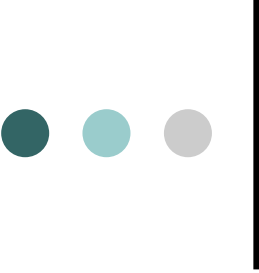
- Accurate identification of ischemic ST-segment
- Critical prognostic information (i.e number leads)
- Complementary to troponin in categorizing ACS
- Time is of the essence (Pre-hospital ideal)
- Accurate interpretation key (while symptomatic)
- Applicable to patients with symptoms
- Acute arrival time is used

STE MI	NSTE MI	UA
 <p>ST Elevation on BBB new or not old</p>	 <p>New ST Deviation</p>	<p>No persistent ST deviation</p>
Troponin +	OR Troponin +	Troponin -



# Indicator Highlights - Troponin

- Troponin
  - Replaced CK-MB as GOLD standard;
  - TnT or I accepted
  - Serial v.s. Isolated and Point-of Care testing
  - Peak levels after 6 hours
  - False positives (most accurate in 1<sup>st</sup> time AMI)
  - Significant level (2 SD) Intermediate Coronary Syndrome
  - Time of chest pain/symptom onset critical
  - Terminal marker of necrosis
  - IMA evolving as negative predictor



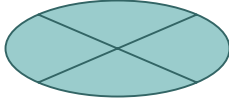
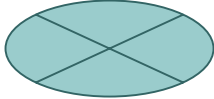
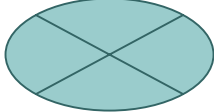
# Indicator Highlights – Cardiology Involvement in 24 hours

- Cardiologist in initial 24 hours
  - May delay treatment or prompt less than optimal level of care if systematic approach not addressed
  - Local unavailability can be addressed through telemedicine, documented phone consultation
  - Cardiologist, Fellow, Resident with appropriate supervision
  - Catheterization assumes involvement

# Continuum of Coronary Artery Disease

*Days*

7 30 60 360

	<i>Primary Prevention</i>	<i>Secondary Prevention</i>	<i>Initial Presentation</i>	<i>Discharge</i>	<i>Follow-up</i>
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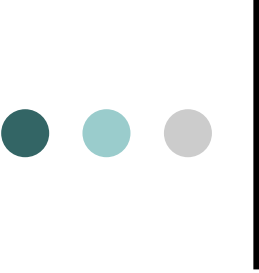


# Use and Timing of Early Invasive Treatment at Initial Presentation

- Optimize the timely use of early invasive strategies for high risk candidates
- Series by Name –

For Hospitalized ACS patients:

- Appropriate receipt of reperfusion subcategorized by thrombolysis and PCI (PM)
- Timely administration of thrombolytic therapy (PM)
- Timely receipt of primary PCI (PM)
- Mean (▲ Median) time to thrombolytic therapy (SI)
- Mean (▲ Median) time to PCI (SI)



# Indicator Highlights- Revascularization

- High risk candidates
  - \*STEMI/BBB, troponin positive, <12 hours from onset
  - NSTEMI, troponin positive
- Routine invasive v.s. selective invasive NSTEMI controversy
  - GP IIb/IIIa Receptor Blocker
  - Platelet Aggregation Inhibitors
  - LMWH
- Agents reteplase, tenetepase, alteplase, streptokinase
- Insufficient evidence favoring stenting over PTCA
- Effect depends on timing (within 6 hours – outside 12 hours)
- \*30 minutes door-to-needle thrombolytic (30 minutes-NHAAP)
- \*120 minutes door-to-treatment PCI



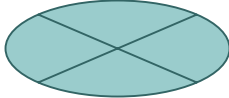


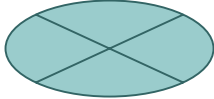



# NSTEMI Early Invasive Strategy

- Recurrent Angina, in spite of medical treatment
- Elevated troponin
- New ST depression
- CHF
  - S3 gallop
  - Worsening rales
  - Chest xray evidence of pulmonary edema
  - New /worsening mitral insufficiency
- High risk finding on non-invasive stress testing
- EF<40% on non-invasive study
- Hemodynamic instability
- Sustained V tach
- Prior CABG
- PCI within previous six months

# Continuum of Coronary Artery Disease

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<i>Clinical Events</i>					



# Continual Assessment and Risk Stratification

- Optimize the diagnosis and management of ACS through stratification into appropriate treatment groups prior to and after discharge
- For ACS patients:
  - High and moderate-high risk - Diagnostic Catheterization prior to discharge (PM)
  - High and moderate-high risk – Seen by Cardiology in 60 days (PM)
  - Moderate-low risk – Plan for further work-up to include stress testing and possible catheterization prior to discharge (PM)



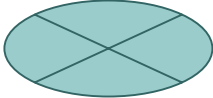
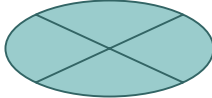
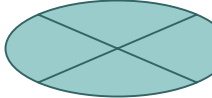


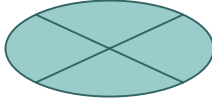



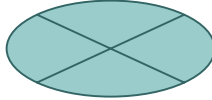

# Indicator Highlights

- Who /When
  - High and moderate high risk patients must have cardiac catheterization prior to discharge
  - Moderate-low must have a plan at discharge including stress testing and angiography
  - Will accept higher level of care
- Efficient use of resources indicates visit with Cardiology in 60 days for High and Moderate-high risk
- **Bottom line: did the risk match treatment regardless of who supplied care**

# Continuum of Coronary Artery Disease

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	<i>Primary Prevention</i>	<i>Secondary Prevention</i>	<i>Initial Presentation</i>	<i>Discharge</i>	<i>Follow-up</i>
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# Risk Factor Modification and Secondary Prevention

- Stabilize vulnerable plaques through statin- and other agent mediated lowering of lipids
- Series by Name –

For Post hospitalized ACS patients:

- ACS post hospitalization (greater than 8 weeks) with lipids  $<100$  (PM)
- ACS post hospitalization (greater than 8 weeks) with lipids  $\geq 120$  (PM)





# Indicator Highlights

- The Lipid Panel
  - Measured within 24 hours of admission v.s. pre-discharge v.s post discharge (within 12 weeks)
  - Statins and other agents without LDL-c measurement and adjust at first visit v.s. not dependent on LDL
  - When to start - i.e. CCU
  - Controversy over correct LDL goal
    - Threshold effect
    - Absolute gain not linear (higher LDL/ higher gain)
- Agent – Statins majority of trials
- Applies to CAD equivalent patients (Diabetes and non-cardiac vascular disease)



# Other Considerations

- ACC/AHA Guidelines revision
  - Medication use glycoprotein IIb/IIIa Inhibitors, LMWH, antiplatelet therapy
- Structure issues
  - Telemedicine Hub Spoke
  - Facility Characteristics
    - Cardiologist/ catheterization availability
    - Urban, rural, tertiary
    - ER Resources and skills
    - Transfers
    - High volume locations simply perform better
- Significant Endpoints
  - Mortality at 30, 90, 180, 365
  - Non fatal MI
  - Worsening Heart Failure, Cardiac arrest, Recurrent severe ischemia, Stroke



# Important Notes ...

- 411 added to 410 population to inpatient sample
- Expand sampling to follow this group into their outpatient continuum of care
- JCAHO Measure related to ASA, Beta Blocker, ACEI and LVEF assessment continue

## Pathophysiology

Plaque Vulnerability

Inflammation

Plaque Disruption

Platelet Activation Clotting

Intracoronary Thrombus

Coronary Flow

Reduced Blood Flow

Ischemia

Myocardial Ischemia

Necrosis Scar

Myocardial Necrosis

## Performance Measures

Screening Hyperlipidemia/ Tobacco  
Tobacco counseling  
High risk 60 Day FU with Cardiology  
Lipid Measurement  
Anti-platelet Therapy

Appropriate and timely  
Revascularization

Timely ECG  
24 Hour Cardiology Involvement  
Predischarge Dx Catheterization  
Predischarge Plan for further testing

EF Assessment BB/ ACEI Use  
Timely Serial Troponin

### Quadrants



### Functional Status

^cancer\*

Cardiovascular \*

## Heart Failure

- Heart failure
- Hypertension

- Ischemic Heart

## Ischemic Disease

AMI - Inpt ECG in hospital within 10 minutes of arrival

AMI - Inpt Risk  
Cardiology  
involvement in 24  
hours STEMI and  
troponin +

Access	PM QD
Total:	8
Exceptional:	2
On Target:	--
At Risk:	--
Underperforming:	6
VHA Best:	--
Above Nat'l Avg:	--

Healthy Communities	PM QD
Total:	0 --
Exceptional:	-- --
On Target:	-- --
At Risk:	--
Underperforming:	-- --
VHA Best:	--
Above Nat'l Avg:	--

Cost	PM QD
Total:	5
Exceptional:	--
On Target:	3
At Risk:	--
Underperforming:	2
VHA Best:	--
Above Nat'l Avg:	--

Quality	PM QD
Total:	47 6
Exceptional:	7 2
On Target:	19 3
At Risk:	6
Underperforming:	15 1
VHA Best:	--
Above Nat'l Avg:	--

Functional Status	PM	QD
Total:	3	--
Exceptional:	1	--
On Target:	2	--
At Risk:	--	--
Underperforming:	--	--
VHA Best:	--	--
Above Nat'l Avg:	--	--

Satisfaction	PM	QD
Total:	0	--
Exceptional:	--	--
On Target:	--	--
At Risk:	--	
Underperforming:	--	--
VHA Best:	--	
Above Nat'l Avg:	--	

## Underperforming

Immunizations - Influenza Outpt - Eleven Clinics

Immunizations - Influenza Outpt - SCI

CAP - Outpt - Influenza Immunization Prior to Admit

AMI - Inpt Reperf Thrombolytic Therapy in 30 min STEMI

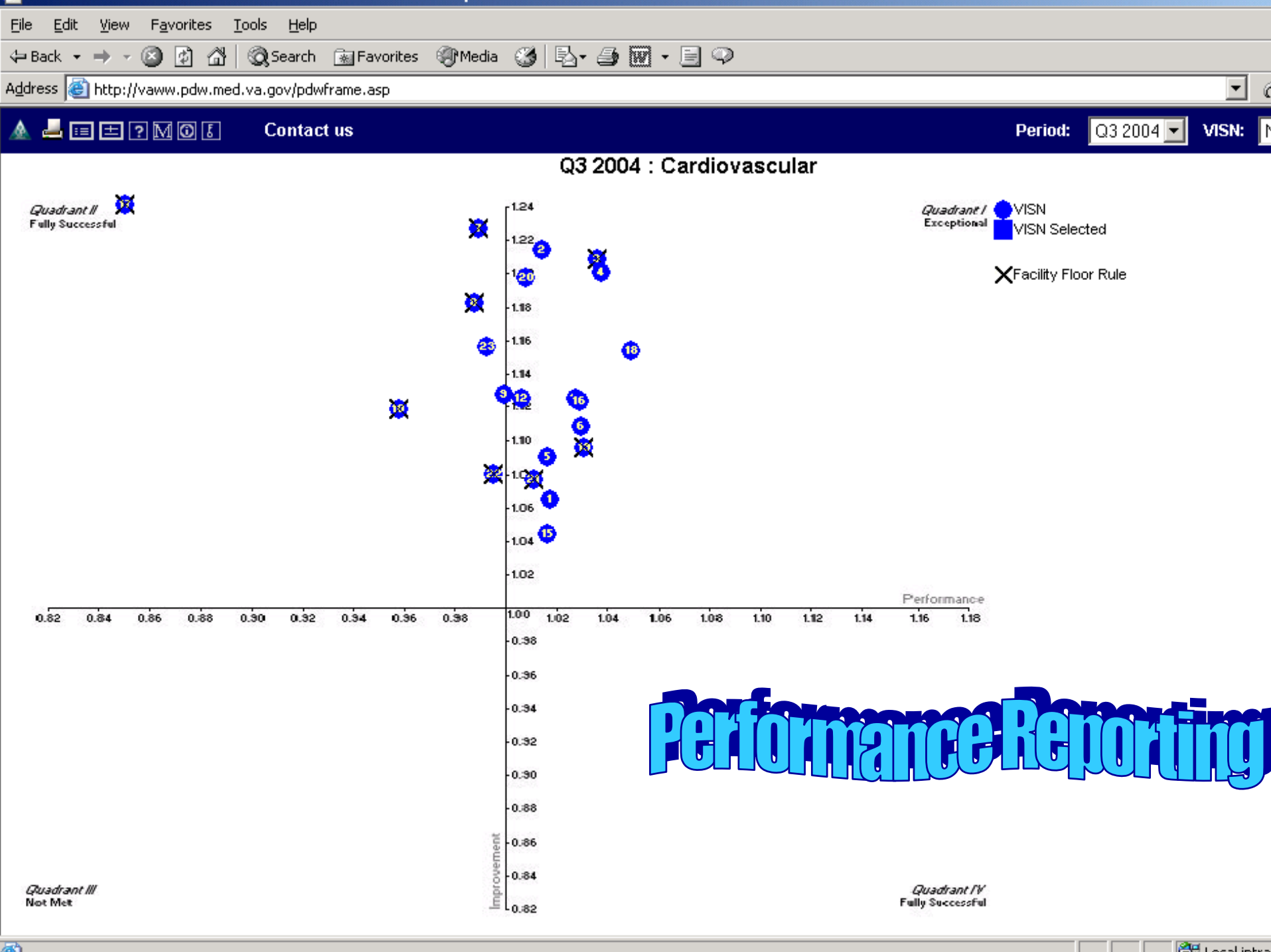
AMI - Inpt Reperf PCI in 120 min STEMI

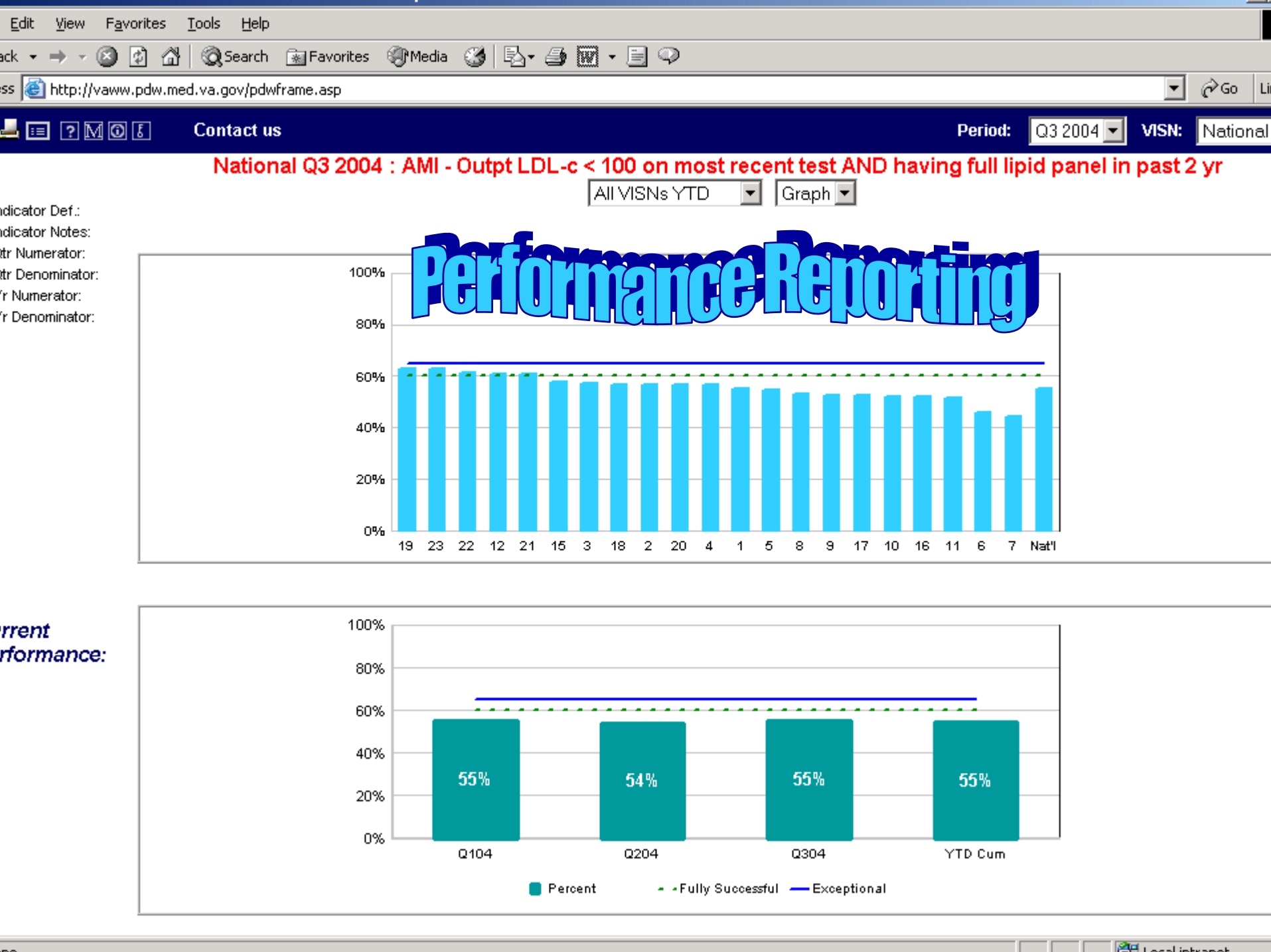
AMI - Inpt Troponin returned within 60 minutes of initial draw

AMI - Inpt ECG in hospital within 10 minutes of arrival

Tobacco - Outpt Counsel 3x/yr - SCI

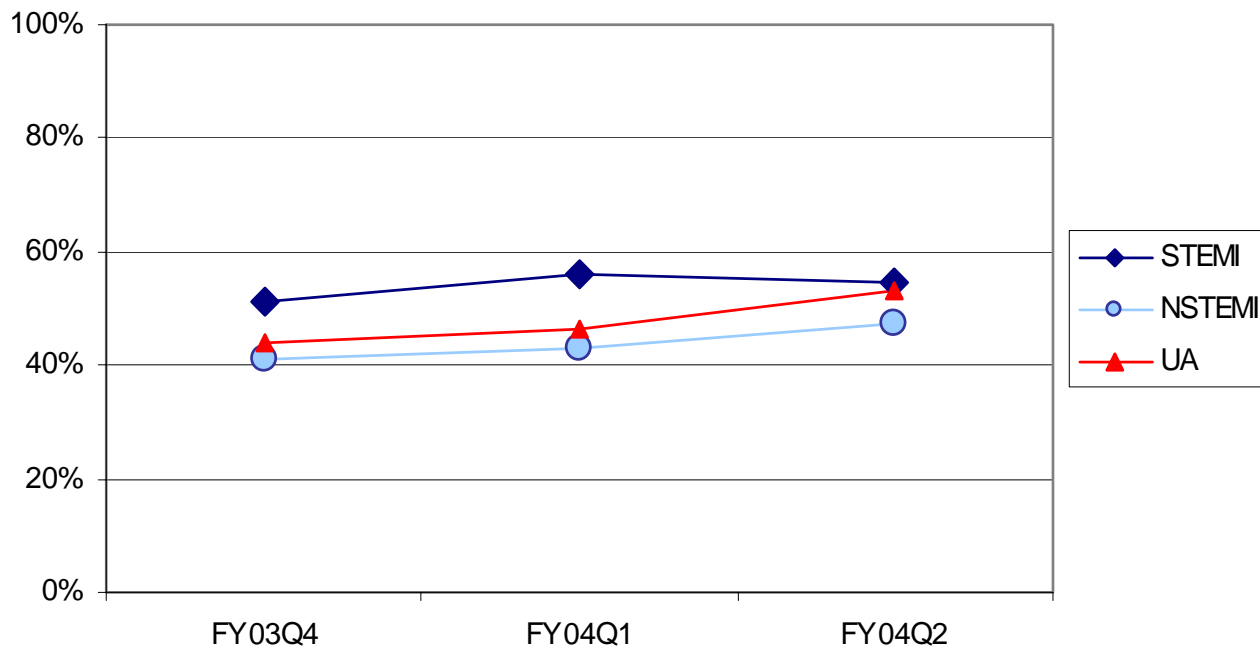
Tobacco - Outnt Used in the past twelve months - MH





# End Of Year Reporting

## Inpatient ECG in Hospital within 10 Minutes of Arrival



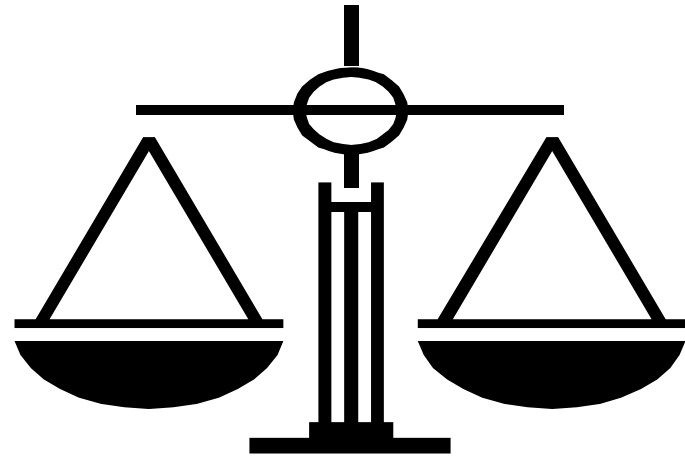
	FY03Q4	FY04Q1	FY04Q2
STEMI	51%	56%	55%
NSTEMI	41%	43%	48%
UA	44%	46%	53%



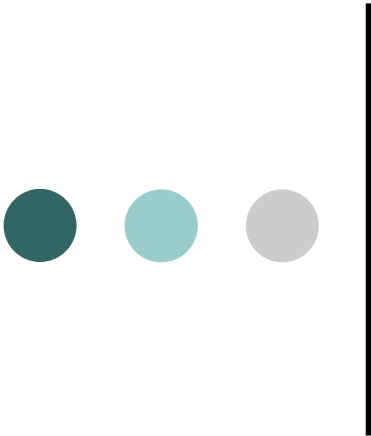
# Public Health Policy and Performance Measurement

Be careful which policy you drive,  
it just might happen...

*Chain of logic that the  
evidence must support to  
link the preventive service to  
improved health outcomes*



Primary Prevention ↔ Risk Factor Assessment ↔ Diagnostic Screening ↔ Therapy ↔ Intermediate Outcome(s) ↔ Long Term Outcome(s)



*Move VHA toward a system that identifies level of high, moderate, and low cardiovascular risk and thus understands and manages risk across time and at the same level of care regardless of site of entry*

## **Contact**

**[carla.cassidy@hq.med.va.gov](mailto:carla.cassidy@hq.med.va.gov)**

**[roxane.rusch@hq.med.va.gov](mailto:roxane.rusch@hq.med.va.gov)**



# **Cardiovascular Clinical Practice Guideline Metrics**

**Margaret A. Hawthorne  
LTC(P), AN  
Quality Management  
Chief, Evidence-Based Practice  
Fort Sam Houston, Texas 78234**



## **Hypertension**

- **Percent of eligible patients with an active diagnosis of hypertension whose most recent blood pressure recording was:**
  - **Less than 140/90**
  - **Equal to or greater than 160/100 or no BP recorded in the past year**



# JCAHO ORYX MEASURES

## AMI

- % of patients given aspirin at arrival of ER
- % of patients prescribed aspirin at discharge
- % of patients with AMI or left ventricular ejection fraction level < 40% be prescribed an ACEI at discharge
- % of AMI patients with a history of smoking within the past year received smoking cessation advice or counseling
- % of patients prescribed a beta-blocker at discharge
- % of patients on a beta-blocker at arrival
- Time to thrombolysis (30 minutes)
- Time to PTCA (90 minutes)
- % Inpatient mortality

### Future Core Measures

- Lipid profile drawn within 24 hours of patient arrival for AMI
- % of patients with abnormal lipid profile results with documented plan for lipid management
- AMI mortality within 30 days post AMI



**JCAHO**

## **Heart Failure Core Measure Set**

- **% Heart failure discharge instructions to patient and/or caregiver to include: understand the prognosis of heart failure, the rationale for pharmacotherapy and prescribed medication regimen, dietary restrictions, and activity recommendations, and the signs and symptoms of deteriorating condition**
- **Number of heart failure patients with documented left ventricular function (LVF) evaluation**
- **Number of heart failure patients who are prescribed Angiotensin Converting Enzyme Inhibitor(ACEI) for left ventricular systolic dysfunction (LVSD)**
- **% of HF patients with a history of smoking within the past year received smoking cessation advice or counseling**



# JCAHO

## Disease-Specific Care Standardized Heart Failure Measure Set

- Monitor Body Weight
- 90-day return visit to emergency department or admission for heart failure after emergency department discharge for heart failure
- Heart Failure patients with documentation that they or their caregivers received written instruction and/or educational materials addressing all of the following:
  - diet
  - weight monitoring
  - activity level
  - medications
  - symptom management
- Number of patients in which current medication drug dose and frequency is documented in the medical record
- Heart Failure patients with documented left ventricular function (LVF) evaluation
- Heart Failure patients who are prescribed Angiotensin Converting Enzyme Inhibitor(ACEI) for left ventricular systolic dysfunction (LVSD)
- The number of heart failure patients screened for or given influenza vaccination
- The number of heart failure patients screened for or given pneumococcal vaccination
- The percentage of enrolled patients with heart failure with blood pressure <140 systolic, <90 diastolic recorded for the reporting period



# Outpatient CVD Metrics

- % of patients on aspirin at most recent visit or contraindication documented
- % of patients on Beta Blocker at most recent visit or contraindication documented
- % of patients with LVEF <40 on ACEI at most recent visit
- % of patients screened for tobacco use in past twelve months
- % of patients with full lipid profile done within past two years
- % of patients within past 2 years were advised of any lifestyle changes



# Web Resources

[www.QMO.amedd.army.mil](http://www.QMO.amedd.army.mil) \*

[www.OQP.med.va.gov/cpg/cpg.htm](http://www.OQP.med.va.gov/cpg/cpg.htm) \*

**QMO Web Site - Microsoft Internet Explorer**

Address: <http://www.qmo.amedd.army.mil>

**U.S. Army MEDCOM Quality Management Office**

**Monday, April 28, 2003**

This site is brought to you by the Quality Management Office, MEDCOM, Headquarters.

We are continually assembling information which can be accessed from the menu bar on the left side of the page.

We have large quantities of information to publish, and desire to make this site your source for the latest information from our office.

**QM Conference Cancelled**

The Quality Management Conference scheduled for 2-6 June 2003 in conjunction with the AUSA Symposium regrettably will NOT be held. The conference to date has NOT been rescheduled. Thanks to all of you who have taken the time to provide feedback, ideas and develop educational programs in support of this office and conference. Again, thank you and we apologize for any inconvenience this may have caused.

**Quality Management Helpful Links**

- Tricare - Quality of Healthcare Report to Congress FY 2001
- National Quality Management Program Newsletters On-Line

**The National Forum For Health Care Quality Measurement and Reporting**

The NQF is a private, non-profit public benefit corporation created in 1999 to develop and implement a national strategy for healthcare quality measurement and reporting.

Go to web site...

**Web Links Disclaimer**

Links to non-federal organizations are provided solely as a service to our users. Links do not constitute an endorsement of any organization by the Army Medical Department (AMEDD) or the Department of Defense and none should be inferred. The AMEDD is not responsible for the content of the individual organization's web pages found via these links.

**On-Line Ordering System for Clinical Practice Guideline Tool Kit Supplies**

Visit our new on-line shopping system available to Army facilities to replenish supplies of the Clinical Practice Guideline Tool Kits. Order refill items for multiple CPGs at one time. Receive an email confirmation of your order with your order number and summary. Once your order is shipped you can track it right on our web site.

Click Here to Check It Out...

**The Surgeon General's Excalibur Award**

List of 2002 Winners and Award Program Introduction

- Policy Memorandums
- Evaluation Criteria
- Improvement Award Template
- Frequently Asked Questions

Please feel free to comment on the content and layout of this site. Our goal is to serve you, our customer, to the best of our ability. Please e-mail the webmaster with comments and ideas. Thank You!

Privacy & Security Notice

**Clinical Practice Guidelines**

Office of Quality and Performance

**What's New!**

- Diabetes Mellitus (DM)
- Post Operative Pain
- Chronic Obstructive Pulmonary Disease (COPD)
- Health Tips for CHF
- Chronic Heart Failure (CHF)
- Dyslipidemia (LDLPS)
- Erectile Dysfunction (ED)
- Low Back Pain (LBP)

**Clinical Practice Guidelines**

Implementation of evidence-based clinical practice guidelines is one strategy VHA has embraced to improve care by reducing variation in practice and systemizing "best practices". Guidelines, as generally tools to improve the processes of care for patient safety, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research. The guidelines on this site are those endorsed by VHA's National Clinical Practice Guidelines Council.

**VHA Guidelines**

VHA, in collaboration with the Department of Defense (DOD) and other leading professional organizations, has been developing clinical practice guidelines since the early 1980s. Guidelines for the establishment of stroke and amputation and the Care Guide for Ischemic Heart Disease were among the first distributed throughout VHA in 1986 and 1987. Since that time, numerous others, including guidelines on Diabetes Mellitus, COPD, Major Depressive Disorder, Psychiatric, Tobacco Use Cessation, Hypertension, and more, have been developed and distributed for implementation throughout the system.

VHA defines Clinical Practice Guidelines as recommendations for the performance or exclusion of specific procedures or services for specific disease entities. These recommendations are derived through a rigorous methodological approach that includes a systematic review of the evidence to outline recommended practice. Guidelines are regularly updated as the body of knowledge evolves. As a set of rules, in a standard format, for solving a problem in a finite number of steps, Clinical guidelines are used by many as a potential solution to inefficiency and inappropriate variation in care. However, it is acknowledged that the use of guidelines must always be applied in the context of a provider's clinical judgment for the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format.

**Navigation Links:**

- Home Page
- Search
- FAQ
- About OQP
- Contact OQP Webmaster
- Privacy & Security Statement
- Freedom of Information Act
- Contact Us
- Accessibility

\* Where to obtain and reorder CPG Toolkits & materials.

# Aggregate Army Metrics, Trended Diabetes Mellitus Portal, NQMP and HEDIS Data

The screenshot displays the U.S. Army MEDCOM Quality Management Office (QMO) website. The page features a navigation menu on the left with links to Practice Guidelines, Patient Safety, ICAHO, Risk Management, CCQAS, Credentialing, Policies, Case Management, Corporate Quality, Resources, FAQ, Contact Us, and QMO Home. The main content area is titled "CLINICAL PRACTICE GUIDELINES" and includes a section for "On-Line Ordering System for Clinical Practice Guideline Tool Kit Supplies" and a "Shop For CPG Items Now" link. Below this, there are several "NEW" banners for various guidelines, including "VA / DoD Guidelines and Tool Kits Available and Anticipated", "CPG Metrics and Benchmarks", "Military Healthcare System Population Health Portal (MHS Portal)", "Aggregated Army Data", "Trended Asthma Portal Data", "Trended Diabetes Mellitus Portal Data", "Fort Benning CPG/CP Regulation", and "Guideline Champion Information". Red arrows point from the text labels on the right to specific sections of the website: "Aggregated Army Metrics" points to the "Aggregated Army Data" banner, "Trended CVD and DM Portal" points to the "Trended Diabetes Mellitus Portal Data" banner, and "NQMP and HEDIS Data" points to the "NQMP Health Plan" link in the bottom left.

QMO: Practice Guidelines Page - Microsoft Internet Explorer  
Address: http://www.qmo.amedd.army.mil/pguide.htm

U.S. Army MEDCOM  
Quality Management Office

CLINICAL PRACTICE GUIDELINES

To email comments, questions or concerns regarding Clinical Practice Guidelines or tool kits, click here.

Asthma  
Tobacco Use Cessation  
PAIN  
Post-Operative Pain  
Deploying Health Care  
Post-Deployment Health  
DEPRESSION  
Low Back Pain  
Pregnancy  
Diabetes

On-Line Ordering System for Clinical Practice Guideline Tool Kit Supplies  
Shop For CPG Items Now

Clinical Practice Guidelines  
Patient Care Team  
Guideline Toolkit  
Army and Air Force Order On-Line  
Click Here to Check It Out...

VA / DoD Guidelines and Tool Kits Available and Anticipated  
Click here to view dates

CPG Metrics and Benchmarks  
FY04 Performance Plan between Deputy Secretary of Defense and Asst Secretary Defense (HA)  
Entire Performance Plan  
Summary Table  
2002 Health-Related Behavior Survey among Military Personnel  
Healthy People 2010  
National Committee for Quality Assurance (NQMP) Health Plan

Military Healthcare System Population Health Portal (MHS Portal)  
Military Health System Portal  
Aggregated Army Data  
Trended Asthma Portal Data  
Trended Diabetes Mellitus Portal Data

Fort Benning CPG/CP Regulation  
Thank you to Fort Benning for sharing their local CPG/CP Regulation.  
Click here to view document

Guideline Champion Information  
Manual for Facility Clinical Practice Guideline Champions  
Responsibilities of the National Clinical Practice Guideline Champion & Team Members  
Rand Manual - "Putting Practice Guidelines to Work in the Department of Defense Medical System" (2001)  
Guideline for Guidelines

June 2003...

Aggregated  
Army Metrics

Trended CVD  
and DM Portal

NQMP and  
HEDIS Data

# Military Healthcare System Population Health Portal

## MHS Population Health Portal



Improve the Health Status of your Population with the ...  
Air Force Population Health Portal  
Naval Population Health Navigator  
Army Population Health Information Connection  
... the one tool for all Services, known as the MHS Portal.

A Tri-Service web-based tool which generates detailed "Action Lists" for Clinical Preventive Services, Disease and Condition Management at the Provider and Clinic level for your enrolled beneficiaries.

Click through "Index Card" design  
Standardized tabular reports with Excel® spreadsheet options  
Detailed methodological guidelines with national benchmarks  
Service level headquarters accounts with aggregate reports available



**Demographics Tab:**  
Population data stratified by preventive service, age, and gender

**Preventive Services Tab:**  
Proactively monitor six preventive services through action lists  
Track your success with national HEDIS® benchmarks  
Childhood immunizations currently limited to Air Force MTFs and one Navy demonstration site

**Disease/Condition Management:**  
Aggressively manage 10 disease or conditions with action lists  
Prevalence reports and aggregate counts  
Track your success with national HEDIS® benchmarks

Request an account today at <https://pophealth.afms.mil/tsphp>



The MHS Portal was developed to meet the Services' request for actionable information for Population Health and Medical Management. Championed by the Population Health and Medical Management (PHMM) Division at TRICARE Management Activity in collaboration with the Population Health Support Division in San Antonio and our Service partners.

**PHMM Mission:**  
Provides policies, instructions, programs, forums, and resources to measure, improve, and sustain the health status of the population.

**PHMM Vision:**  
We are the definitive source for population health information to facilitate the transformation of the MHS from a reactive to proactive healthcare system.

**Population Health and Medical Management Division**  
Office of the Chief Medical Officer, TRICARE Management Activity,  
5111 Leesburg Pike, Suite 810, Falls Church, VA 22041  
703.681.0064, DSN 761.0064, FAX 703.681.1242

### SERVICE RESOURCES

*Air Force Population Health Portal*  
Lt Col Phillips, USAF, MC  
AF Population Health Support Division  
210.532.4265 or DSN 240.4265  
[clark.phillips@brooks.af.mil](mailto:clark.phillips@brooks.af.mil)

*Naval Population Health Navigator*  
Mrs. Betty Ruschmeier  
BUMED-MUMC  
202.762.3139 or DSN 762.3139  
[etarrusmeier@us.med.navy.mil](mailto:etarrusmeier@us.med.navy.mil)

*Army Population Health Information Connection*  
LTC(P) Margaret A. Hawthorne  
MEDCOM-MCHO-Q  
210.221.8297 or DSN 471.8297  
[margaret.hawthorne@medd.army.mil](mailto:margaret.hawthorne@medd.army.mil)

<https://pophealth.afms.mil/tsphp/login/login.cfm>